CLEAR FORM

Psychological Therapies Program Referral

Please note the psychological therapies program offers intake assessment, service navigation and short-term psychological intervention for people experiencing mild-to-moderate mental illness and living in the Toowoomba, Lockyer Valley and Somerset LGAs.

Client Information:

Full Name:	Mr/Mrs/Miss/Ms/Other_____
Preferred Name:	Date of Birth:
Gender: ☐ Male ☐ Female ☐ Other_____	Phone no:
Preferred pronouns:	
Address:	
Email:	
Main language spoken at home:	Interpreter required: ☐ Yes ☐ No
Cultural background: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐ Prefer not to say	
NDIS Participant: ☐ Yes ☐ No ☐ Unsure If yes are psychosocial supports included in their plan ☐ Yes ☐ No ☐ Unsure	
Is the client aware of and consenting to this referral: ☐ Yes ☐ No ☐ Unsure If under 16 years, the parent/carer of the young person has provided consent for this referral: ☐ Yes ☐ No ☐ Unsure If no or unsure, please provide details: _____	

Emergency Contact Information:

Full Name:	Mr/Mrs/Miss/Ms/Other_____
Relationship with client:	
Phone Number:	Email:

Family Services Australia

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At the completion of this referral please email to ***triage@familyservices.org.au***
If you have any questions, please contact Family Services Australia at 1800 FSA 000 (1800 372 000) [Option 2]

Referrer Details: please complete * section before sending the referral)

Name:	Profession:
GP Name*:	Practice Name*:
Phone Number:	Fax (if applicable):
Email:	

Clinical information:

Formal diagnosis of mental health condition: _____
In the past 4 weeks, has the client had thoughts about hurting or killing themselves: ☐ Yes ☐No
Client has been hospitalised for Mental Health concern in last 12 months: ☐ Yes ☐ No
Duration of mental health intervention required: ☐Short term ☐ long term ☐ Crisis
GP mental health treatment plan developed: ☐ Yes ☐ In process of development
Reason for referral/presenting concerns:

Family Services Australia

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Outcome tool used: (■ one option)

☐ K10, Score _____	☐ K5, Score: _____
☐ SDQ (Parent 4-10 years) score: _____	☐ SDQ (Parent 11-17 years) score: _____

Are there any known risk concerns? E.g., self-harm, suicidality, risk to others, etc. If yes, please provide details below.

Other contributing factors/relevant information, e.g., co-existing medical conditions, abuse, grief/loss, substance use, social stressors:

Please send this completed referral form, along with any additional relevant information via email to triage@familyservices.org.au. If you have any questions, please contact us on 1800 372 000 (Option 2).